HOW TO FILE A LIEN

Filing a Notice and Request for Allowance of Lien is how you assert a claim or right against a workers' compensation case.

Enclosed is a lien form. Complete the form. Be sure to sign and date it.
Attach a full statement or itemized bill supporting the lien and justifying the right to reimbursement.

A WCAB case number must be entered on the top right hand corner of the lien. If there is no WCAB case number, contact the local I & A office.

Send the original to the WCAB and copies to all parties. It is important that you check the box indicating all parties have been served.

Employee's consent to allowance of lien and signature is not required.

Keep a copy for your records.

If you need help, you may call an Information & Assistance Office. The local I & A phone numbers are listed on the back of this guide.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92801
1661 N. Raymond Avenue, Ste. 200 (714) 738-4038
Information & Assistance Unit

BAKERSFIELD, 93309
1800 30th Street, Rm.100 (661) 395-2514
Information & Assistance Unit

EUREKA, 95501-0421
100 "H" Street, Rm. 201 (707) 441-5723
Information & Assistance Unit

FRESNO, 93721-2280
2550 Mariposa Street, Rm. 4078 (559) 445-5355
Information & Assistance Unit

GOLETA, 93117
6755 Hollister Avenue (805) 968-4158
Information & Assistance Unit

GROVER BEACH, 93433-2261
1562 Grand Avenue (805) 481-3296
Information & Assistance Unit

LONG BEACH, 90802-4460
300 Oceangate Street, 3rd Floor (562) 590-5240
Information & Assistance Unit

LOS ANGELES, 90013
340 West 4th Street, 9th Floor (213) 576-7389
Information & Assistance Unit

OAKLAND, 94612
1515 Clay Street, 6th Floor (510) 622-2861
Information & Assistance Unit

POMONA, 91766
435 W. Mission Blvd., Suite 300 (909) 623-8568
Information & Assistance Unit

REDDING, 96001-2796
2115 Akard, Rm. 21 (530) 225-2047
Information & Assistance Unit

RIVERSIDE, 92501
3737 Main Street, Ste. 300 (909) 782-4347
Information & Assistance Unit

SACRAMENTO, 95825
2424 Arden Way, Ste. 230 (916) 263-2741
Information & Assistance Unit

SALINAS, 93906
1880 North Main Street, 1st Floor (408) 443-3058
Information & Assistance Unit

SAN BERNARDINO, 92401-1888
464 West Third Street, Ste. 239 (909) 383-4522
Information & Assistance Unit

SAN DIEGO, 92101-3690
1350 Front Street, Ste. 3012 (619) 525-4589
Information & Assistance Unit

SAN FRANCISCO (DISTRICT OFFICE), 94102
455 Golden Gate Ave., 2nd Floor (415) 703-5020
Information & Assistance Unit

SAN JOSE, 95113
100 Paseo de San Antonio, Rm. 223 (408) 277-1292
Information & Assistance Unit

SANTA ANA, 92701-4080
28 Civic Center Plaza, Ste. 451 (714) 558-4597
Information & Assistance Unit

SANTA MONICA, 90405-5200
2701 Ocean Park Blvd., Std. 222 (310) 452-1188
Information & Assistance Unit

SANTA ROSA, 95404
50 "D" Street, Ste. 430 (707) 576-2452
Information & Assistance Unit

STOCKTON, 95202-2314
31 East Channel Street, Rm. 417 (209) 948-7980
Information & Assistance Unit

VAN NUYS, 91401-3373
6150 Van Nuys Blvd., Rm 105 (818) 901-5374
Information & Assistance Unit

VENTURA, 93003-6085
5810 Ralston Street, Rm. 115 (805) 654-4701
Information & Assistance Unit

WALNUT CREEK, 94598
175 Lennon Lane, Rm. 200 (925) 977-8343
Information & Assistance Unit

As of May 18, 2000

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

(Print or type names and addresses; include ZIP Codes)

ID OR CASE NO.

Injured Worker	Address
Date of Claimed Injury	Social Security Number / Date of Birth
Attorney for Injured Worker	Address
Employer	Address
Insurance Carrier or, if Self-Insured, Certificate Name	
Adjusting Agency, if Agency Administered	Address Where Claim Administered
Attorney for Employer/Carrier	Address
Lien Claimant	Address and Telephone No.
Attorney for Lien Claimant	Address and Telephone No.

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of _____ Dollars ($ _____) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for *(Mark appropriate box):*

☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or

☐ The reasonable medical expense incurred to prove a contested claim; or

☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or

☐ The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or

☐ The reasonable fee for interpreter's services performed on _____, 19 _____.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or

☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

☐ a copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant | Signature of Lien Claimant | Date

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker